Relational Psychoanalysis

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GLOSSARY

intersubjectivity A developmental achievement in which both individuals within a dyad recognize each other's subjectivity.
multiple selves The concept that people experience themselves not as unitary and unchanging but as consisting of multiple selves that may be compatible or incompatible with one another.
mutuality The idea that both patient and analyst participate in the analytic process, that they mutually regulate or influence each other, consciously and unconsciously.
projective identification A process by which the patient's disavowed feelings are projected onto the analyst who has become a container for the dissociated features of the patient's experience.
transference-countertransference matrix Transference and countertransference are interdependent, mutually determined experiences that are shaped by both patient and analyst.

I. DESCRIPTION

Relational psychoanalysis is an intensive form of psychotherapy that places human relations at the center of motivation, psychopathology, and treatment. It is an alternative to classical Freudian psychoanalysis (including its modifications in psychoanalytic ego psychology). It considers relations to others, not drives, as the basic building blocks of mental life. From the relational perspective, individual experiences and the internal structures of the mind are viewed as deriving from and are transformations of relationships with significant others.

The term "relational psychoanalysis" is a relatively new coinage. It refers to a theoretical and clinical sensibility that integrates a variety of psychoanalytic theories that have evolved following the promulgation of Freud's seminal ideas. Thus, it is a contemporary eclectic approach that has been in a process of growth and development in the United States for the last 20 years. This new perspective includes recent developments within, and cuts across, U.S. interpersonal psychoanalysis, the British school of object relations, self psychology, and currents within contemporary Freudian theory. It is concerned with the intrapsychic as well as the interpersonal, but the intrapsychic is seen as constituted by the internalization of interpersonal experiences. Although these internalized interpersonal experiences may be biologically mediated, relational psychoanalysis is primarily concerned with the psychological determinants of experience.

There is considerable variation in the practice of relational psychoanalysis, but all relational analysts share a sensibility in which the therapeutic relationship plays a superordinate role in the treatment. Thus,
the analyst's subjectivity and personal involvement, including partially blinding entanglements, are given serious consideration. Gender, class, race, culture, and language are additional factors of great significance to relational analysis.

II. HISTORICAL DEVELOPMENT

The sea change that has been taking place in contemporary U.S. psychoanalysis in the last two decades is in sharp contrast to the popular view that modern-day psychoanalysis is a footnote to Freud. Psychoanalytic practice has evolved considerably since Freud's original creative contributions. Freud's body-based instinct (drive) model emphasizes intrapsychic conflict among id, ego, and superego as the child passes through the psychosexual stages of development. Interpretation, the main form of clinical intervention in Freudian analysis, is for the purpose of making unconscious content, such as sexual and aggressive impulses, conscious. In the Freudian model, relatedness is a derivative of the primary drives of sex and aggression.

The current paradigm shift away from the classical drive model to the relational model had its origins in the work of two psychoanalytic pioneers: the Europeans Sandor Ferenczi and Otto Rank. Both were students of Freud and in 1924 collaborated in exploring the primacy of experience in the here and now of the transference. After their collaboration, Ferenczi theorized about the mutuality of relationships in human development and clinical process. Rank went on to elaborate a theory of the birth of the self and the centrality of early relationships in the therapeutic interaction.

Working in the United States before World War II, Harry Stack Sullivan revised Freudian psychoanalytic ideas in his development of an interpersonal psychiatry. In an informal collaboration with Erich Fromm, Karen Horney, Frieda Fromm-Reichman, and Clara Thompson, Sullivan came to disagree with the prevailing view of psychopathology as residing in the individual. He believed that human beings are inseparable from their interpersonal field and that focusing on the individual without considering past and present relationships is misdirected. Sullivan emphasized that human relatedness is a prerequisite of psychological well-being and a safeguard against anxiety. In treatment, he urged concentration on the here and now of the therapist-patient interaction. Subsequently, Thompson assembled the emerging concepts that constituted an interpersonal psychoanalysis and helped institutionalize them through the Washington School of Psychiatry and the William Alanson White Institute in New York City. Over time, two different clinical approaches emerged in the interpersonal tradition: Sullivan's emphasis on empathy and tact and Fromm's emphasis on frankness and confrontation. In stressing the role of actual and specific interpersonal relationships in personality development and psychopathology, interpersonal psychoanalysis came to be caricatured as social psychology by the mainstream and medical psychoanalytic power circles of the day. In recent years, however, interpersonal psychoanalysis has gained increased acceptance with the elegant writings of Edgar Levinson, who stressed that what was talked about between analyst and patient was also concurrently being enacted between the two.

Contemporary American object relations theories began to have a significant presence in the United States in the 1970s. The theoretical and clinical innovations of the British school stressed the importance of the pre-oedipal stage and especially the early mother-infant relationship. Emphasis was placed on the conflictual nature of internalized relationships to others. Moreover, nonverbal phenomena, de repressed states, and the actual relationship between analyst and patient were also highlighted. Melanie Klein's theorizing about greed, envy, aggression, and projective identification also played an influential role. As represented by Michael Balint, W. R. D. Fairbairn, D. W. Winnicott, and Harry Guntrip, the British school of object relations was a forerunner for U.S. Freudian psychoanalysis in that the centrality of the Oedipus complex was downplayed.

A third psychoanalytic paradigm that contributed to relational approach is self psychology. In the late 1970s, Heinz Kohut reformulated Freud's ideas, first in terms of the concept of narcissism and then in terms of theory and practice. He emphasized the chronic traumatizing milieu of the patient's early human environment, not the intense sexual and aggressive pressures that Freud had defined as basic to human motivation. He viewed aggression and rage in treatment not as an expression of a fundamental force but as result of deep vulnerability. The self psychology school of psychoanalysis developed into a powerful presence and influenced the thinking and practice of many.

In their more contemporary cast, these three schools of psychoanalysis seemed to be moving along similar paths, toward a focus on self-other relations, an interest in feelings and experience rather than drives, and toward a less authoritarian stance on the part of the analyst. Furthermore, the clinical focus is often on the patient-analyst relationship and the way in which small, but subtle interactions and enactments dominate the clinical situation.
Other theoretical influences in the development of a relational approach were the works of Hans Loewald and John Bowlby. Hans Loewald, a prominent ego psychologist in the 1970s, redefined id, ego, and superego in terms of interpersonal experience giving drives a relational character. He argued against the Freudian idea that the human mind can be an independent unit of inquiry without taking into account the analyst’s participation. John Bowlby’s work on attachment theory in the 1960s and the subsequent rich research on attachment has also played an important role in recent relation theorizing. Bowlby and his followers have placed intimate attachments to others at the “hub” around which a person’s life revolves throughout the life span.

In 1983, Jay R. Greenberg and Stephen A. Mitchell published their landmark treatise, Object Relations and Psychoanalytic Theory, in which they distinguished two distinct approaches to psychoanalytic theory: the drive-structure model and the relational-structure model. Despite its title, their book was not only about object relations theories. It compared various models including interpersonal theory and self psychology. In addition to making detailed comparisons, the authors argued that theoretical positions in psychoanalysis are inevitably embedded in social, political, and moral contexts. They used the term relational to bridge the traditions of interpersonal relations, as developed within interpersonal psychoanalysis, and object relations, as developed within contemporary British theorizing.

During the early 1980s, Merton Gill, a prominent leader in U.S. ego psychology, published a series of articles recognizing the contributions of the interpersonal theorists and their views. He contrasted the drive model with the more humanistic model in which relationships are given primary importance. He identified the depth of clinical process and the exploration of transference-countertransference issues as the defining characteristics of clinical psychoanalysis. Later in the decade, the English translation of The Clinical Diary of Sándor Ferenczi was published after having been suppressed for more than half a century. Consisting of Ferenczi’s clinical experiments with mutual analysis, it demonstrated an objection to the hierarchical arrangement of the traditional analytic relationship between an analyst who dispenses interpretations and a patient who receives them.

Conceptually, two other broad developments occurred in the last two decades of the 20th century that facilitated the development of relational psychoanalysis. The first development was feminism. It launched a major critique on Freudian notions by deemphasizing the phallocentricty of its theories and practice. Sexuality was unlinked from both physical constitution and reproductive function, and homosexuality no longer pathologized. Using a feminist approach, Jessica Benjamin published The Bonds of Love in 1988. This work masterfully argued the importance of psychoanalytic theory to include both an intrapsychic and an intersubjective perspective. The second development was constructivism, in its moderate postmodern form. Basically, psychoanalytic theorists have used a constructivist approach to critique essentialism, positivism, and any pretext to objectivity. Constructivism is used to understand transference not as simply a distortion emanating from the patient as in Freudian psychology. Transference, according to Irwin Hoffman, is viewed as involving the analyst’s subjectivity in a process of co-creation with the patient. In his 1998 book Ritual and Spontaneity in the Psychoanalytic Process, Hoffman brilliantly critiques theorists such as Sullivan, Kohut, and Winnicott charging that they are similar to Freud in that they suggest that analysts can keep their own subjective experience from “contaminating” their patients’ transferences.

Organizationaly, relational psychoanalysis was greatly bolstered by four developments. The Division of Psychoanalysis of the American Psychological Association operating outside the control of the traditional American Psychoanalytic Association acted as a forum for the relationally minded psychoanalyst and allowed for numerous creative and scholarly panel presentations at its annual conferences. This in turn gave relational psychoanalysis a national network and identity. The second organizational development took place in 1998 at the New York University Postdoctoral Program in Psychoanalysis and Psychotherapy where a “relational track” was established to go along with its Freudian, interpersonal, and independent tracks thus adding a prestigious university training legitimacy to relational psychoanalysis. Third, the establishment of the highly successful Psychoanalytic Dialogues: A Journal of Relational Perspectives in 1990 led to further consolidation of the identity of relational analysts. Finally, the formation of the International Association of Relational Psychoanalysis and Psychotherapy is well under way and will be inaugurated with a clinical conference in New York City in January 2002 titled Relational Analyses at Work: Sense and Sensibility.

III. THEORETICAL CONCEPTS

As articulated by Jay Greenberg and Stephen Mitchell, there are at least two different and incompatible views of human nature in psychoanalysis. Drive
theory is derived from a philosophical tradition that sees a person as an essentially individual animal and human goals and desires as essentially personal and individual. In contrast, relational theory holds the philosophical position that a person is a social animal and that human satisfactions are realizable only within a social community. Consequently, the relational position is not interested in the single mind as a unit of study. It is interested in the relationship as a unit of study.

Although unconscious processes, the Oedipal complex, dreams, slips of the tongue, and free associations are of importance to relational theorists, they do not hold privileged positions. Wary of privileging any conceptual notion, relational theory nevertheless places the conscious and especially the unconscious relationship between patient and analyst at the heart of the therapeutic effort.

The relational matrix involves conflict, constructivism, and an overarching two-person perspective. Unconscious conflict is central to the drive model. In this model, the analyst strives to help the patient come to understand that sexuality and aggression are not as dangerous as they appear to be to the patient's fantasy-dominated child's mind. In the relational model, the traditional notion of conflict is maintained, but it is understood as containing conflicts over loyalties to parents, an idea attributable to W. R. D. Fairbairn's object relations theory. Thus, conflict is not located "in the person" but rather conflict may best be explained as both intra- and interpersonal.

Constructivism in psychoanalysis holds that the observer plays a role in shaping, constructing, and organizing what is being observed. Psychoanalysis is a particular method for organizing what is into unique patterns, but the patterns can be understood and organized in any number of ways. Thus, ambiguity and uncertainty are features of all human relatedness. This does not necessarily lead to nihilism. On the contrary, the observer can propel thought toward further elaboration and synthesis. For Irwin Hoffman, the paradigm shift in contemporary psychoanalysis is not necessarily from the drive model to the relational model, but from the positivist model to the constructivist model. Thus, the great divide is between dichotomous and dialectical thinking. What is meant by dialectic is a process in which each of the two opposing concepts creates, informs, preserves, and negates the other, each standing in a dynamic relationship with the other. Among the pairs of phenomena Hoffman considers dialectically are doubt and certainty; possibilities and constraints; hierarchy and egalitarian relations; risk taking and responsibility; neurotic and existential anxiety; psychoanalysis as an instrument of healing and as cultural symptom; the analyst's intentions versus the patient's will; action and reflection; and analytic rituals and the analyst's spontaneity. Last, constructivism in psychoanalysis holds that analytic therapists do not have privileged access to their own motives, nor are they able to know exactly what is best for their patients. Hence, the patient's perception of the analyst's subjectivity is critical.

Stephen Mitchell has argued that the distinction between a monadic theory of mind (a one-person psychology) and an interpersonal relational theory of mind (a two-person psychology) is pivotal to understanding psychoanalytic concepts. In general, those theories greatly influenced by classical analysis have been referred to as one-person psychologies. They emphasize the individual experience of the patient and view the analyst as a blank screen onto which the patient projects wishes and fantasies. The two-person psychologies are influenced by the notion of the analyst as co-participant in the therapy. Emmanuel Ghent has described the history of psychoanalysis as constituted by dialectical shifts between one-person and two-person psychologies. Neil Altman has added to the dialogue by suggesting that we consider not a one-or two-person psychology but a three-person psychology. A good example of a three-person psychology would be thinking through the therapeutic relationship as it operates in a particular clinic or in conjunction with a specific insurance company.

Another important concept in relational psychoanalysis is that of intersubjectivity. Jessica Benjamin's work on intersubjectivity emphasizes mutual recognition as an intrinsic aspect of the development of the self. She argues that we need to maintain a tension in our theory between relating to others as objects and relating to others as separate subjects. The infant research of Daniel Stern on the development of a sense of self yields evidence for intersubjective relatedness, a relatedness that includes the recognition of subjective mental states in the other as well as in oneself. By contrast, for Robert Stolorow and his colleagues, the term intersubjective is applied whenever two subjectivities constitute the field, even if one does not recognize the other as a separate subjectivity.

Recently, relational thinkers have been hypothesizing about how the mind is structured in an effort to redefine notions of the self. The self has usually been thought of as a continuous, unitary phenomenon. Philip Bromberg has described a state of multiple selves. This concept holds that people experience themselves not as unitary and unchanging but as consisting of multiple selves that may be compatible or incompatible with one another. For example, an adult self may be taking in a logical
explanation about an interaction, while at the same
time a child self simply feels vulnerable and angry. Mul-
tiple self-states are created not by unmet developmental
needs, but by unattached, sometimes traumatic, early
interactions with significant others. The therapeutic
goal is to bring the different self-states into awareness
and into a useful dialogue and not necessarily integra-
tion. For Jody Messler Davies multiple selves suggest a
central role for the process of dissociation and conse-
sequently a very different vision of the unconscious.
Unlike drive theory, that utilizes the metaphor of an onion
or an archaeological site for the unconscious, Davies
prefers the metaphor of a kaleidoscope with each glance
through the panes of a moment in time provides
a unique view and an infinite constellation of in-
terconnectedness.

A fundamental principle in the relational model of
psychoanalysis is that of mutuality. Mutuality is a
process in which patient and analyst mutually regulate
or mutually influence each other both consciously and
unconsciously. What is regulated is subtle, but it can
often involve feelings, thoughts, and actions. Heinrich
Racker pointed out that analysis is not an interaction
between a sick person and a healthy one, but rather an
interaction between two personalities, each with
healthy and pathological dynamics. Thus, the classical
authority of the analyst has given way to a more dem-
ocratic, respectful exploration of a joint reality. Mutu-
ality means that the analyst and the patient are partners
in the treatment, albeit unequal ones. This mutuality
requires a certain type of emotional honesty from both
participants. In the relational model, the analyst cannot
function as a blank screen or a detached observer en-
couraging intense feelings in the patient and respond-
ing in a neutral manner. When mutuality in the clinical
process is taken into account, dialectical tensions can
arise. One such dialectical tension occurs between the
patient's sense of the analyst as a person like himself or
herself and the patient's sense of the analyst as a person
with superior and magical power. Although the analyst
engages in relative subordination of personal interests,
the resolution of such tensions can be powerful emo-
tional experiences for both participants.

IV. CLINICAL PROCESSES

The clinical attitude conveyed by a relational analyst
depends very much on the particular analyst's personal-
ity, training, and the specific impact of a particular pa-
tient. She does not act as a judge of reality and nor does
she presume that there is only one way to see something
accurately. The patient's own sense of reality is greatly
respected and encouraged. Compliant surrender to the
analyst's presumed superior vision is not encouraged.
The patient's observations and perceptions about the
analyst are encouraged. Notwithstanding these atti-
attitudes, it is likely that there will develop repetitive reen-
actments of some of the most wounding features of the
patient's earlier experiences. These reenactments will
likely involve the analyst and consequently also involve
a range of feelings from attraction to conflict in relation
to the analyst.

To a large extent, traditional analysis requires that
the analyst interpret the true meaning of the patient's
reactions to her. In contrast, when a patient feels dis-
content with her analyst, the relational approach re-
quires both parties to examine how and why they are in
conflict and to negotiate the conflict as best they can.
This is a shift involving a move away from interpreting
observer to active participant. The in-depth explo-
ration will require that both parties track the way the
patient's observations lead to conclusions about the
analysis and how they might be reenactments in the here
and now of earlier relationship difficulties.

Clinical psychoanalysts have tended to centralize the
experiences of early childhood. The relational orienta-
tion acknowledges this importance as well, but it does
not consider the uncovering of the past to be the major
task of treatment. In the classical approach, the pa-
tient's problems are the result of repression; cure entails
the release of impulses, fantasies, and memories from
repression. The analyst interprets both the content of
the repressed and also the ways the patient is defending
against the content. The analyst helps the patient gain
insight thereby releasing from repression unconscious
conflicts and thus being cured. A number of relational
approaches, particularly the British object relations
school and the self psychology school, assume that
from the moment of birth, the child's whole being has
developed in the context of experiences with others.
Normal development is thwarted due to inadequate
parenting. What is curative in the analytic relationship
is the analyst offering some form of basic parental re-
sponsiveness that was missed early on. The interper-
sonal approach regards the analyst's response to the
patient as organized not along parent-child lines but
rather along adult-to-adult lines requiring honest re-
sponses and engagement. Hence, relational analysis
differs with respect to their use of efforts to reanimate
stalled developmental processes or their use of frank-
ness and authentic confrontations. For many espousing
a more integrated relational approach, however, the be-
lief is that the patient can be both child and adult. Both
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the realities and the fantasies of early childhood experiences are important to understand in detail, but the realities and fantasies of adulthood are also important to understand in detail.

In the most general sense, all psychoanalytic treatment paradigms value the analysis of transference. The relational paradigm, however, considers more than just the transference; it values the transference-countertransference matrix. Transference represents the emergence of feelings toward early childhood figures, displaced onto the person of the analyst. Historically, countertransference is the displacement of feelings from the analyst's past into the analytic situation. This was considered a seriously negative developmental in the analysis. The analyst was enjoined to rid herself of it through self-analysis or to return to her own psychoanalyst for help. Relational analysts have a different approach. They believe that countertransference is a normal state of affairs and that it can advance the analytic work. The transference-countertransference matrix is mutually determined and shaped by the conscious and unconscious beliefs, hopes, fears, and wishes of both patient and analyst.

The clinical approach of the relational model holds that the analytic situation is more than an arena for playing out the past; it is also where the patient is firmly engaged in the present. Thus, the patient is not simply displacing feelings from earlier relationships onto the analyst; he or she is likely to have observed a great deal about the analyst and to have constructed a plausible view of her. This view is, in part, based on the patient's own past and his typical way of organizing experience. For example, an analyst can be experienced by a patient as critical of certain actions on the patient's part, and indeed that may be an opinion of the analyst. However, an in-depth exploration of a patient's observations about the analyst can show that the criticism is different from the patient's mother and does not require allegiance from the patient for a personal connection to be maintained.

With the qualification that indeed psychoanalysts can suffer from the very same problems they are trying to assist patients with, relational ideas stress that countertransference can be (a) an ordinary, common response to the sort of interpersonal positions and pressures a patient can set up; (b) an analyst-patient reenactment of a patient's past relationships; (c) a complex result of the patient's projective identification, and (d) something the patient is doing to strike responsive chords in the analyst.

Given that all analysts have a less than complete understanding of their own defenses, and that the patient may have picked up features of the countertransference that the analyst is not aware of, some analysts like Lewis Aron and Irvin Hoffman have argued for the usefulness of extended explorations of the patient's experience of and hypotheses about the analyst's experience. Such explorations give permission to patients who grew up feeling that their perceptions of their parents were forbidden and dangerous, and discounting their own observations albeit subtle and sometimes unformulated. Aron prefers to speak of the analyst's subjectivity instead of the analyst's countertransference. He believes that the term 'countertransference implies that the analyst's experience is reactive rather than subjective. The patient's perception of the analyst's subjectivity does not replace the historical analytic focus on the patient's experience, but it is seen as one component of the analysis.

To a large extent, relational analysts view self-disclosure as a form of intervention. It may involve the analyst revealing to the patient information, such as her thoughts or feelings about an interaction, something about the analyst's personal life, or the analyst's values and biases. Although the information may be useful, it is not disclosed as curious. Other information besides the analyst's countertransference is necessary to confirm an idea about the patient's experience or to provide an interpretation. Nonetheless, many relational analysts believe that judiciously chosen self-disclosures can be helpful.

Finally, the two-person framework is interactive and makes more demands on the analyst to be attentive to the field—from disclosures that may momentarily focus attention on the analyst's mind, through analysis of interaction, to interpretation of the patient's intrapsychic activity. Clinical techniques are not to be objectified into a hard set of rules and regulations. Rather, psychoanalytic techniques are an interlocking set of clinical concepts that the analyst uses as a framework for analyzing the unique interactive matrix. The dialectical tension between the rules of restraint in the analytic relationship and the analyst's personal participation is a major controversy in contemporary psychoanalysis. The relational framework considers the joint critical reflection of such dialectical events crucial to the clinical process.

V. CONCLUSION

Relational psychoanalysis is a selective integration of various theoretical approaches. Its origins can be traced to contributions by various psychoanalysts and schools of psychoanalysis primarily interpersonal psychoanalysis, British object relationists, and self psychology. In the
And now to begin ...

**References**


**Footnotes**

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